Meeting Minutes
Health Information Technology Council Meeting

September 8, 2014
3:30 – 5:00 P.M.

One Ashburton Place, 21st floor Conference Room
Boston, MA

Meeting Attendees

Name	Organization	Attended
John Polanowicz	*(Chair) Secretary of the Executive Office of Health and Human Services*	Yes
Manu Tandon	*(Chair) Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Yes
Bill Oates	*Chief Information Officer, Commonwealth of Massachusetts*	Yes
David Seltz	*Executive Director of Health Policy Commission*	No
Aron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	*
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Yes
Eric Nakajima	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	No
Patricia Hopkins MD	*Representative from a small Physician group Practice Rheumatology & Internal Medicine Doctor (Private Practice)*	No
Meg Aranow	*Senior Research Director, The Advisory Board Company*	Yes
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Yes
John Halamka, MD	*Chief Information officer, Beth Israel Deaconess Medical Center*	Via Phone
Normand Deschene	President and Chief Executive Officer , Lowell General Hospital	No
Jay Breines	Community Health Center	Yes
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	No
Michael Lee, MD	*Director of clinical Informatics, Atrius Health*	Yes
Margie Sipe, RN	*Performance Improvement Consultant; Massachusetts Hospital Association (MHA)*	Yes
Steven Fox	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	Yes
Larry Garber, MD	*Medical Director of Informatics, Reliant Medical Group*	Yes
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Yes
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences*	Yes
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	Yes
Kristin Thorn	*Acting Director of Medicaid*	Yes

Guest

Name	Organization
Robert McDevitt	EOHHS
Darrel Harmer	EOHHS
Kathleen Snyder	EOHHS
Amy Caron	EOHHS
David Bowditch	EOHHS
Claudia Boldman	ITD
Jennifer Monahan	MAeHC
Micky Tripathi	MAeHC
Mark Belanger	MAeHC
Jessica Costantino	AARP
Rick Wilson	Mass Health
Kris Williams	EHS
Margot Carleton	BAMSI
Christine Griffin	PHS / MGH
Sara Moore	Tufts/ MC
David Bachand	NEQCA
Daniel Wiseman	Lowell General Hospital
Brian Sandager	Lowell General Hospital
Lisa Fenichel	Consumer Healthcare / Advocate
Stacey Piszcz	EOHHS
Bala Burra	EOHHS

Meeting called to order – minutes approved

The meeting was called to order by Secretary Polanowicz at 3:35 P.M.

The Council reviewed minutes of the August 4, 2014 HIT Council meeting. The minutes were approved as written.

Discussion Item 1: Achieving Meaningful Consent (Slides 3-8)

See slides 3-8 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

John D. Halamka, MD, Chief Information Officer (CIO) at Beth Israel Deaconess Medical Center (BIDMC), presented via phone on how the organization implemented consent.

(Slide 4) Existing Processes – Generally, it was not so much that the notion of opt in consent was controversial- it was that we really had to engage the patients and families. We had to determine how best to communicate it, how best to obtain a meaningful consent at the point of which a patient encounter occurs. Whether the patient is sick or injured, they should understand what it is they are consenting to. Before, we had a general consent form that did not enumerate the Mass HIway. It just said- treatment at BIDMC for care coordination and Treatment Payment and Operations (TPO) -it was not specific to what data, or the patient controls. There was a hybrid model that came up: an electronic medical records release form for insurance information for people pursuing disability. The patient wants data sent to the Social Security Administration (SSA) seeking disability payments. As part of the process the patient signs a piece of paper at the SSA office, then an XML document is electronically transferred to BID and BID sends the information back to the SSA office. So, we had some precedent of opt in an electronic way.

(Slide 5) The "Push" Use Case – Phase 1 of the HIway was our push use case – going from point to point. Typically, summary information was being sent from Primary Care Provider (PCP) to PCP, PCP to specialist or Emergency Department (ED) back to PCP. We already had in our consent [processes] this idea of a very limited exchange of information as part of care coordination, treatment, payment, and operations (TPO). So, as was decided by the HIT Council and various other groups who had discussed it, there wasn't a need to revise the process on this push use case. In fact it is covered by the Health Insurance Portability and Accountability Act under (HIPPA) and HIPAA Omnibus rule within our organized healthcare arrangements.

(Slide 6) The "Pull" Use Case – Organizations outside of Beth Israel may request information about a patient such as Partners requesting from BID, or any western located office sending to an eastern area hospital. Our notion here was that this was a good idea, it is absolutely imperative for care management and population health, but first let's makes sure the patients understand what they are consenting to in a way that not only addresses Chapter 244, but also passes the 'Boston Globe test.' We gathered together our Patient and Family Council for an hour long presentation of the HIway with examples. They looked at the original forms from the state and felt they were too vague, not specifically highlighting the nature of the HIway and not clearly delineating a choice or that if at some future time you decide to change your mind, you can reverse your yes to a no.

(Slide 7) General Agreement Example – We took the topography of the form and surrounded the most important information by a box. We want to make sure the yes/no is a firm choice and make it clear that this is unrelated to their general care. You can still say no and receive care just fine. Currently this is in pilot at a number of sites and those pilots are going well. We trained all of our professionals and gave them copies of the education materials, including a Frequently Asked Questions (FAQ) sheet so they can answer patient questions. Overall the workflow is good, the understanding is good, and next week will have some early opt in data to share.

(Slide 8) Questions –

- Question (Laurance Stuntz): What was the primary feedback from the staff- did they feel it really impacted workflow?
    - Answer (John Halamka): They did not think it would be a significant impact because there was an easily readable patient education piece the State created. They are already passing out forms that need signatures, and as I understand, the patient education materials were so well written there were not a lot of questions.
- Question (Secretary Polanowicz): Have you already shared what the patient educational materials look like?
    - Answer (John Halamka): We took the language the State developed and did some formatting, but it was truly inspired by the fine work that has been done at EOHHS. We have a Forms Committee which reviewed the documents and made minor changes.
    - Comment (Michael Lee): The Mass HIway fact sheet was quite good so we are using it right out of the box.

Overall, while there is certainly a thought that opt in consent is harder than opt out consent, once you actually execute it with patient and family engagement, using existing workflows, it is extraordinarily positive from a Boston Globe perspective and so far we have not seeing anything negative come out of this.

- Comment (Michael Lee): One of the tricks on the ambulatory side is that we do not collect consent as part of the check-in process. We had to create a form and it was a process we did not have before. We had to build the eventualities in like we wanted to know if they had already received the form so we did not keep having them sign multiple times. We also wanted to make it so that a child turning 18 was prompted for a new consent. All of those features took us awhile to build in even though it was all part of the same process. It was trickier on the ambulatory side just because the whole consent concept is not part of usual our workflow.
- Comment (Karen Bell): Looks good John.

Discussion Item 3: Partner's Healthcare- Enterprise Consent Model for the Mass HIway (Slides 10 - 18)

See slides 10-18 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Christine Griffin, Consent Project Manager, Health Information Services at Massachusetts General Hospital, presented on how the organization implemented consent.

(Slide 10) Objectives – One of the things I found most striking was how quickly we were able to implement the consent process despite the complexities we ran into. We hope that by sharing our experience with other organizations they will be able to chart their own course. Deborah Adair was asked to shepherd the process for Partners. She is proof of what you can do with strong leadership, ownership, and the right team. All three were integral to the process.

At Partners we had the goal of Meaningful Use as the real driver and wanted to meet the Stage 2 measures with a strict deadline of October 1st to start sending Transition of Care (TOC) documents over

the HIway. That framed what we were going to do, but we also wanted to maximize the opportunities for patients to opt in. We knew we needed consent, knew we wanted to ask one time, and we wanted to track responses electronically. We also knew by pooling consent we had a greater chance of meeting Meaningful Use goals.

(Slide 11) Need a reliable, efficient and centralized way to track patient consent across the continuum…

(Slide 12) Existing Processes - As John mentioned, we also looked at our existing processes first. We did not have a standardized consent to treat form throughout the organization but we did have the HIPAA Notice of Privacy Practices (NPP) which we give to each patient at their first visit and track electronically. This feeds into the electronic Master Patient Index (eMPI) with a consistent cohesive process across the whole organization. We also have the patient portal which we use to communicate with patients, but we knew not all patients were using the portal. We also had the Protected Health Information (PHI) release form which is in paper and used only as needed.

(Slide 13) Strategy - Drawing on the existing processes the decision was made to have the workflow mirror the privacy notice collection. On top of this health information exchange (HIE) effort Partners is implementing a new integrated EHR system. This adds a little more stress, but also was an opportunity for us to find a way to start collecting consent as the new system goes live. A new field was built into the registration system and the HIway consent form was added to a documents table in the EHR which lists the documents the patient needs to sign. The registration stuff is already part of the front office workflow and now they can check if the patient has opted in or out as well. If they have not given a preference they are handed the HIway fact sheet created by EOHHS, which we are also using right out of the box. We are hoping that if all organizations are using the same, or similar, fact sheets patients will feel more comfortable with the language. We also had electronic signing - electronic signature pads that automatically updated the patients status in the EHR. If patients do not sign at all they must be opted out manually. There was also an option for patients to say they need more time or want more information and they will then be prompted at their next appointment. Not all sites will be up on the new system right away, we started in July with the new form. Other sites are creating a flag within the registration system, or are using an existing flag, and the local flags lead up to the organizational eMPI to populate future visits.

(Slide 14) Future State – Right now we are only collecting consent at registration areas. Going forward the hope is to start using the patient portal so patients can review all of the information at home. This [patient portal consent] would also interface with the eMPI. We would also like a display in the EHR showing the patient's preference so the provider can see easily if there is consent and send a referral electronically over the HIway.

(Slide 15) HIway Toolkits Here... – We knew that the only way to be successful in asking staff to take on another task was to make it as easy as possible for them. We developed a toolkit and printed 500 copies. It was also posted on the Privacy and Security page of our website so practices could print and make their own guides. The toolkit contains a lot of helpful information including: a business card with one sentence to introduce the HIway, a phone number so that patients can call the privacy office,

patient education materials, a copy of the consent form, instructions for what to do in the system, a screenshot of the system showing where and how to document the consent, as well as a HIway script with potential questions patients might ask with clear answers, a PowerPoint deck and finally a spreadsheet showing what was actually in a transition of care document. We also created a Massachusetts General Hospital version that highlighted the benefits of using the HIway. The goal is to give staff a broad range of knowledge.

(Slide 16) Enterprise Consent Data Model for MA HIway - Epic feeds into EMPI . The EMPI will be the source of truth to help Partner's automate sending out documents.

(Slide 17) Team Participation – Again we want to give credit to Deborah Adair for putting together a great team. A HIway consent workgroup started in February and had representation from Health Information Systems, Information Systems, Patient Access- registration areas, PeCare (Partners eCare initiative) team, Providers and Legal - endorsed and supported by leadership.

(Slide 18) Next Steps – There is still a lot of work to do with physician education. Physicians need to know what to do when they start to receive documents, how they can use the HIway and what we plan to use it for. We looked at what meetings we had in place, saw that we had a lot of Meaningful Use committees and none were really connecting in a cohesive fashion. The goal is to create an HIE Operating Workgroup to add value and efficiency.

- Question (Secretary Polanowicz): When you rolled it out at Partners, are you rolling it out on the inpatient side or the ambulatory as well?
    - Answer (Christine Griffin): We decided to do it all at once with ambulatory and inpatient since all are on Epic. We are continuing to onboard outpatient in the next month or two.
    - Comment (Deborah Adair): For example the Emergency Department wanted to wait until they had the Epic implementation behind them. Groups know it is coming.
- Question (Secretary Polanowicz): Are the normal consent processes you had still in play?
    - Answer (Deborah Adair): Yes.
- Question (Karen Bell): How did you navigate CFR-42?
    - Answer (Deborah Adair): We had a lot of discussion about this and are actually suppressing sensitive data - anything CFR-42 related: Human Immunodeficiency Virus (HIV) testing, some genetic testing and mental health. Those Consolidated-Clinical Document Architecture (C-CDA's) are not going across the HIway. We have a model that checks for a) consent, then b) is it sensitive information. It is so complicated between the state and federal regulations we were not comfortable doing it any other way right now, especially with the state HIV piece because consent must be obtained every single time.
- Question (Laurance Stuntz): Do you mean they do not get shared at all, or just not over the HIway?
    - Answer (Deborah Adair): The HIway- for now they do not go. If we are referring we would need to get the extra consent, the patient would sign it, but for now it is not going.

- Comment (Michael Lee): We get the consent to share electronically when they have a test, and we had to add that it may contain sensitive HIV information. Even though it is per event, we do not believe we can reliably filter the information out. A diagnosis can also be inferred in some cases where patients are taking a very specific prescription. We cannot reliably filter all of it. Our hope is that by putting that note in the consent, those that are concerned will choose not to share. We still want it as part of the consent so patients know what kind of information can travel.
- Question (Laurance Stuntz): Do you have statistics on what percentage of people are opting out?
    - Answer (Deborah Adair): We will in the next few weeks. We went live in July and did reach out to some practice directors who said it has been successful- patients are positive about it and for the most part are opting in.
- Question (Steven Fox): For those that won't opt in, was there an anecdote for why?
    - Answer (Christine Griffin): Some people just don't want anything done electronically. There was also a time factor- wanting the patient to read all of the materials before the visit. We did get a Spanish translation of the HIway materials. That was really important to the practices. We are willing to share the translated version with others.
- Question (Michael Lee): In terms of the phone call follow-ups to the privacy office- how bad was that?
    - Answer (Christine Griffin): Minimal right now. One patient called and was upset because they thought they said yes, and wanted to opt out. We were able to flip the flag to no manually. There have been a couple concerns related to the electronic signature and how it is stored- but nothing strictly related to the HIway.
- Question (Meg Aranow): You said you only asked once- how do you do that with people who are unsure at the first visit, you are asking later?
    - Answer (Christine Griffin): Staff can flip the flag to "unable to obtain"- there are three statuses to choose from. When that "unable to obtain" flag is flipped staff will be prompted to ask again at the next visit until they electively say no or yes.
- Question (Secretary Polanowicz): As your registration system permeates through the organization, does that mean everyone can see those flags?
    - Answer (Christine Griffin): Yes.
- Comment (Larry Garber): I am interested in the full [opt in] statistics. I know that The Massachusetts eHealth Collaborative (MAeHC) put an extraordinary amount of effort into the community HIE projects, educating the patients, staff and clinicians. If that is what we need to do to get higher rates we cannot each do our own marketing and expect to get those results. How much of that is the State's responsibility? Telling people how good this is, how beneficial this is.
    - Comment (Secretary Polanowicz): That is a valid point. I think that is something we should go back to the staff with so they can get information out.
    - Comment (Michael Lee): I think the public awareness around the hacking of healthcare information is very strong, which will impact our rates more so than it did 5 or 6 years

ago with MAeHC. But that is not just the healthcare industry. It includes banks and government institutions. People are not seeing us as saying your information is totally secure, we guarantee this. That is a tough claim to make.
    - Comment (Deborah Adair): I think you will see a sudden increase in the numbers as MU 2 comes on.
- Question (Kristen): Is there a point where there is a discussion between clinician and patient to change that flag at some point in the visit?
    - Answer (Christine Griffin): For the EHR, in addition to having the feed to show opt in or opt out, we discussed putting somewhat of a widget in so the physician can switch the flag if the workflow sits better with someone other than the front desk staff. However, we would still need the form signed.
- Comment (Kathleen Snyder): I actually signed the Partners form a few weeks ago and was thrilled to see the new Mass HIway consent information. From a patient perspective, there was no promoting and the front desk staff did not fully know how to explain the HIway at first, though when I returned to the front after the visit they had the patient education forms out.
- Comment (Deborah Adair): Christine has gone to several hundred providers and we know there is a need to educate the clinicians. It is really the providers we need to get to. Each time they get a C-CDA they need to reconcile the medications. We made the decision that we cannot gear up until all of the providers understand that their name will be on the HIway and there will be things they need to do when that information comes in. It is a new process.

- Comment (Christine Griffin): When we do get the metrics we will drill down to see who is doing it and not doing it. We do spot checks here and there to make sure practices are asking for the forms. With the Epic transformation there is a lot going on, the HIway is a small piece of a large change. Now we need to filter down and see who has not reached out to us for more information.

Discussion Item 4: Mass HIway Update (Slides 20 – 26)

See slides 20-26 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

An update on the Mass HIway was presented by Darrel Harmer, Associate Chief Information Officer – Health Information Exchange at EOHHS.

(Slide 20) Mass HIway 2014 Development Timeline - The development timeline has a lot of projects that have gone into the green. The Healthcare Provider Portal (HPP) Release 1 is live. As was mentioned last month, that is mostly behind the scenes and will help on the administrative side. Right now the Provider Directory changes are keyed in manually and those will become automated. The e-referral went live in June and was integrated into the HIway last week. The Childhood Lead Paint Poison Prevention Program also went live. The Relationship Listing Service (RLS) Release 2 is complete and actually sets the table nicely for the pilot ADT process that will be getting going later this month/early October. This gives web access to the RLS, automated age of majority consent shut off, and notifications like break the seal. We added a new project- Children's Behavioral Health Initiative which will be live in December.

(Slide 21) HISP to HISP Connectivity – The graph has not visually changed too much from last month, but some significant events have happened in the background. Last month I reported that eClinicalWorks (eCW) was requiring some metadata that customers could not produce. The 'big guns' – Micky Tripathi- went in and helped change that for us. There is a lot of testing work going on to get the eCW Health Information Service Provider (HISP) connected. There is definite progress and we have a good shot at getting that finished this month. Also, eCW is now physically connected to the Massachusetts Immunization Information System (MIIS), but is still working through getting the Health Level 7 (HL7) coding right.

- Question (Karen Bell): Are the Epic customers coming in from a HISP? Or one by one?
    - Answer (Michael Lee): Each organization joins the HIway directly.

(Slide 22) Query & Retrieve Pilot Update – BIDMC, Holyoke and Tufts working to get their consented ADT's to us in September/early October. Atrius is aiming for the next couple months.

(Slide 23) HIway Outreach Update – We are working with MAeHC to get the outreach effort going again. We completed a survey of existing customers to identify where they stand in the process which is helping to focus the outreach efforts. As Christine mentioned, there is a webinar on implementing consent this week, then another on PD in October. Another large piece is creating good user facing documentation. We are putting more resources into that.

(Slide 24) August Transaction Activity – There was a significant bump in August- most of that is coming from additional Syndromic transactions. Hopefully we can keep that trend going.

- Question (Laurance Stuntz): Can we break that down by transition of care, versus public health reporting?
    - Answer (Darrel Harmer): We can do some of that. Part of what constrains us is the limited amount of data we are keeping - it would be hard for us to go much beyond this. Right now the data drill down is done manually and we do want to find a way to do that automatically.

(Slide 25) August Participation Activity – Added 4 new Participation Agreements in August. Current total is 225 Mass HIway Organizations.

(Slide 26) August Connection Activity – 2 new organizations went live- 169 Mass HIway connections.

Discussion Item 5: FY 2015 HIway Targets (Slides 28-31)

See slides 28-31 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Massachusetts eHealth Collaborative President and CEO Micky Tripathi

(Slide 28) Conceptual Framework – One of the things we wanted to do was figure out how to get to the next level below those two metrics we had been using; participants and live participants. We did quite a bit of thinking, preliminary data analysis, and vetted the fiscal 2015 targets with the Massachusetts

Hospital Association, Massachusetts Medical Society, and the Massachusetts Council of Community Hospitals. All seem satisfied that we are on target with our targets. Really what we wanted to focus on was making the HIway more useful. This can be done by increasing breath, volume and the range of use cases. The purpose of the metrics is to set some goals as well as external targets for public accountability.

(Slide 29) Preliminary Metrics – The team came up with a few different ways to define the metrics and is starting to align the data, pulling from all different places. Here we have taken a first cut at the kinds of metrics we can look at. The HIway cannot influence the use but it is helpful to have descriptive targets to increase breadth and depth. We want more organizations to join, but we also want all those on already to do more things. First we looked at the simple metrics. We are defining an organization as one legal entity. Partners, for example, is one entity. There are pluses and minuses to doing that. Once you start to break apart legal entities it is harder to figure out. Market penetration, what percentage is actually on the HIway, is basically aligned with the price tiers. In terms of depth, we will look at the number of organizations sending production data, the number of live sending/receiving production transactions, and the number of transactions per segment. These are all different perspectives to give us an idea of how the HIway is growing. In terms of the number of use cases, number of organizations transacting in each use case, there is limited visibility into that and we need to see what we can feasibly surmise from the transaction. Maybe if we start to get a lot of data we can do some sampling of the data. Creating targets for measures 1-4 are things the HIway can influence. Measures 4-8 are things the HIway can monitor.

(Slide 30) Preliminary FY 2015 Targets – The columns in the group on the left are from the rate card. Sub-tier 1A is large hospitals. We have identified 14 as of June 30th, 9 of those are actually live, and 4 are actively transacting on the HIway. That number in production is the key focal point for next year. We really want to focus on getting providers and vendors not only connected, but actually using the HIway. As of the end of June we were at 29% live in production [for tier 1a] and the new goal is to bring it up to 64% of the total. The two big variable categories are the small ambulatory practices. We do not necessarily know how many there are. The number actually changed before the meeting today. In category 4D we are trying to go from one in production, to 80 but that only represents 5% of the total. There are some big leaps and we- tried to set higher goals for segments that are well defined, and have some traction already. We set lower goals that have large and diffusive variable makeup.

- Question (Larry Garber): How do you account for the HISPs? - For example estimate that eCW will bring in x amount of providers?
    - Answer (Micky Tripathi): With eCW live, in principle it would be every eCW customer, but we really want to focus on the ones actually in production. The challenge is that we have no visibility into it. We will know how many are transacting but we do not know the denominator of how many could be transacting.
    - Comment (Larry Garber): When we get eCW and Allscripts you may get half of those.
- Question (Secretary Polanowicz): These were reviewed with the Massachusetts Council of Community Hospitals, Massachusetts Hospital Association and Massachusetts Medical Society. We felt it was important to discuss the numbers with them beforehand. Like you said, with eCW

we will get the numbers, and our job is to build out effective use cases. Not just counting that you're on, but you are actually using it. We have pushed the requirements to the Infrastructure and Capacity Building (ICB) grants. You need a plan to get on the HIE in a relatively reasonable timeline before 2017. Steward has done nothing with the HIE– we checked and 9 of the 10 Steward hospitals received ICB grant money. As a result we would expect that 10 of the 10 would join the HIE, but they are in the same boat. It is not just having your name on the list, but actually utilizing the HIway.

- Comment (Mike Lee): The most recent exemption from the Registration in Medicine (BORIM) for the EHR efficiency requirement was connecting to the Mass HIway.
    - Response (Micky Tripathi): Before we focused on getting the signed Participation Agreement and getting vendors and providers connected. Now we are going to the next level, holding ourselves to a higher bar and driving increased usage of the HIway.
- Question (Meg Aranow): It makes sense to me that we cannot do these things now. Do we need to spin up a parallel group to go back to the Participation Agreements? Have participants agree to certain things and collect information to get closer to measuring quality and not just look at the traffic?
    - Answer (Secretary Polanowicz): I would argue that we should incorporate some of that, but I think we heard from a number of organizations today that there are challenges as organizations are incorporating getting onto the HIway as part of other fairly significant changes. I think the important part is asking "What are the use cases and how do we get people to drive to it?" Fortunately we over sample on quality metrics here, they do not necessarily have to be ones we capture in the HIE, but we should have some thoughts on that, and where that would come from.
    - Comment (Meg Aranow): It would be good to look at the overall impact of the HIE and tie them back to the original goals.
- Question (Karen Bell): Given the emphasis on patient safety and HIT, should we be drawing on resources we have in the street like the National Patient Safety Foundation? Draw on them to think about some metrics to demonstrate that this is not actually going to be a problem with patient safety. Maybe it falls into the realm of preemptive optics.
    - Comment (Micky Tripathi): Perhaps when we think more about Phase 2 would be the best time for that. Exploring the whole unintended piece of this.
    - Comment (Mike Lee): You could have anything from misidentification of patients to medication reconciliation. What do you do if the cardiologist lists the medication, should that be on the med list you keep or not? Do you tell the cardiologist you are taking it off the med list? Formularies are also sometimes different. There are a lot of those HIT safety issues with not knowing what to do with shared information, but I do not know how to really study that other than to be antidotal at this point.
    - Comment (Deborah Adair): We track all of our amendment requests.
    - Comments (Micky Tripathi): I think something in the spirit of an audit makes sense. This is more about what the HIway controls. We could have someone come in and ask, based on the existing literature and research are there different things that should happen?

- Comment (Steven Fox): You can come at it another way. Where we have to already report on it, there could there be additional reporting. We get asked all the time when someone is going to a new facility. Could you show me the medical errors at this facility with this doctor? There are an additional set of questions you could ask to find out if it was something done electronically. People will be looking for this information. Is safety better now? Did cost come down?

(Slide 31) Key Assumptions & Challenges - Particularly with the small ambulatory practices, a lot will depend on connectivity with some of the key HISPs. On the hospital side we need to focus on trading partners and see populating the RLS as a key driver for hospitals. We do not necessarily have a complete line of sight into those sitting behind a HISP, and we do have minimal insight into data which requires some solid extrapolation, not retaining sensitive data by design.

- Question (Laurance Stuntz): Have the HISP's said they will tell us who is using them?
  - Answer (Darrel Harmer): We have asked and in some cases they do not know. From their perspective they have 56 states and territories. If everyone wanted to know that information it would be a burden.
- Question (Larry Garber): Is there a way to show transaction volumes with a map?
  - Answer (Micky Tripathi): We know who is sending, and where, even if behind the eCW HISP we would need to match it up manually. We do know at least who it is coming from. Each of the HISPs are different and some are really focused just on Massachusetts like eLINC/ Winchester and Newburyport. Those will be more forthcoming. It is more the national vendors.
- Question (Steven Fox): What is the process for finalizing the numbers?
  - Answer (Secretary Polanowicz): We had an opportunity to meet with the Hospital Association, Massachusetts Medical Society, and Massachusetts Council of Community Hospitals to go over the targets. The question they had is what if we do not meet them? The reality is that they are guidelines. As we bring on eCW for example, we get a big group of providers, we can then start to think about how to drive use cases and value.
  - Comment (Steven Fox): It would be good as we get into the next part of the calendar to get some of those HISPs in here.

Discussion Item 6: Wrap-Up (Slide 33)

See slide 33 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Wrap-up presented by Darrel Harmer.

The schedule for the 2014 HIT Council Meetings was provided.

- ~~January 13~~
- ~~February 3~~
- ~~March 3~~
- ~~April 7~~

- ~~May 5~~
- ~~June 9~~
- ~~July 7 – cancelled~~
- ~~August 4~~
- ~~September 8~~
- **October 6**
- November 3
- December 8

** All meetings will be held from 3:30-5:00 PM at One Ashburton Place, 21st floor*

The HIT Council meeting was adjourned at 4:55 P.M.